THE RECOVERY KERNEL

Substance-Specific Navigation Series

HOW TO RECOVER FROM CRACK COCAINE

Using the Recovery Kernel Framework

Crack · Freebase · Rock · Stone · Base · Glass · Hubba · Ready Rock

⚠ HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE | Crisis: call 911 or text 988

CRACK COCAINE CAUSES HEART ATTACKS, STROKES, AND SUDDEN PULMONARY CRISIS — AT ANY AGE.

Chest pain, severe shortness of breath, or coughing blood after smoking: call 911 immediately.

A Note Before You Begin

The Recovery Kernel series has a guide for powder cocaine. This is not that guide.

The pharmacology is the same — crack cocaine is freebase cocaine, which is the same molecule (cocaine hydrochloride) processed into a form that can be smoked. The DAT/SERT/NET triple reuptake blockade, the dopamine flooding, the Warrior COMT constitutionnal profile, the cardiovascular risks — all of it applies. The cocaine guide covers the biology in full and this guide cross-references it without repeating every element.

What this guide addresses is what is different. And what is different is significant enough to require its own guide.

The route of administration changes everything. When crack cocaine is smoked, it reaches the brain in approximately 8 seconds. The effect peaks in under a minute and substantially clears in 10–15 minutes. This is the fastest brain delivery of any cocaine administration route. The resulting pharmacokinetic profile — extreme peak, very short duration, precipitous drop — produces the most intense binge pattern, the most severe crash, and the most powerful craving architecture of any substance in this guide series. The rush of smoked crack is qualitatively different from the elevation of intranasal cocaine — more sudden, more total, and more specifically remembered. The memory of it is what drives the return.

The pulmonary consequences are unique to this route — lungs were not built to process vaporized cocaine alkaloid. Crack lung, bronchospasm, chronic respiratory disease, and hemoptysis are specific to smoking and do not appear in the intranasal or oral cocaine profiles.

And then there is what the compendium names directly in its historical timeline: 'Drug policy responses criminalized crack at 100:1 sentencing disparity vs. powder cocaine; disproportionate incarceration of Black communities; treatment infrastructure absent; punishment substituted for medicine.' This sentence is the moral context of this guide. Many people reading it have been touched by the crack epidemic not only through their own use but through incarceration — their own, a parent's, a sibling's — and through the structural aftermath that incarceration produces: criminal records, barriers to housing and employment, family rupture, and community surveillance. The recovery this guide supports must be capable of operating in that context, not beside it.

This guide holds the pharmacology and the politics simultaneously. Because the person who has both survived crack cocaine use and survived what the criminal justice system did with the crack epidemic deserves a framework that sees the whole picture.

Section 0 — Immediate Safety: Read This First

⚠ CRACK COCAINE CAUSES CARDIAC AND PULMONARY EMERGENCIES. CHEST PAIN, SEVERE SHORTNESS OF BREATH, OR BLOOD IN SPUTUM AFTER SMOKING: CALL 911 IMMEDIATELY. DO NOT WAIT.

The Cardiac Emergency

Crack cocaine's cardiac danger is the same as powder cocaine — coronary vasospasm, norepinephrine surge, platelet aggregation — but amplified by the speed and intensity of the smoked delivery. The sudden, massive sympathetic activation of crack smoking can produce cardiac arrhythmia, myocardial infarction, and sudden cardiac death within minutes of a single hit, in people of any age with no prior cardiac history.

- Chest pain, pressure, or tightness — during or after smoking: call 911. Do not wait to see if it passes.
- Jaw pain, left arm pain, or back pain during or after smoking: cardiac emergency. Call 911.
- Sudden severe pounding heartbeat with dizziness or near-fainting: possible arrhythmia. Call 911.
- Sudden severe headache — possible hemorrhagic stroke. Call 911 immediately.

There is no reversal agent for cocaine cardiovascular emergencies. Treatment is supportive — managing the vasospasm, arrhythmia, and sympathetic overdrive while the cocaine clears. Time and emergency care are the treatment.

The Pulmonary Emergency — Crack Lung

THE CENTURION — The Lungs Were Not Built for This — The Crack-Specific Pulmonary Crisis

Crack lung — diffuse alveolar hemorrhage — is a specific and potentially fatal pulmonary emergency that occurs with smoked cocaine and does not occur with intranasal or oral cocaine. The hot cocaine vapor directly injures the lung's alveolar tissue, producing hemorrhage into the air spaces, respiratory failure, and, in severe cases, death.

⚠ CALL 911 IMMEDIATELY FOR ANY OF THE FOLLOWING AFTER SMOKING CRACK: Coughing up blood or blood-tinged sputum. Severe shortness of breath at rest. Rapid breathing with inability to get adequate air. Bluish

coloring of lips or fingernails. These are signs of life-threatening pulmonary emergency.

Pulmonary complication	Signs and symptoms	Response
Crack lung (diffuse alveolar hemorrhage)	Sudden severe shortness of breath during or within hours of smoking. Coughing up blood or dark-brown sputum. Fever. Chest pain. Hypoxia (low oxygen saturation, felt as air hunger).	911 immediately. This is a life-threatening emergency. Supplemental oxygen, ventilatory support, and hospital admission are required. Do not wait for symptoms to improve.
Bronchospasm (acute)	Sudden severe wheeze, tightness in the chest, inability to complete a full breath — during or immediately after smoking.	Move to fresh air. If the person has an inhaler: use it. If severe and not resolving within minutes: 911. Crack-induced bronchospasm can be severe enough to require emergency bronchodilator treatment.
Pneumothorax (collapsed lung)	Sharp, sudden one-sided chest pain. Shortness of breath. Decreased breath sounds on one side. Can occur from the intense inhalation effort of crack smoking rupturing a bleb (small air pocket) in the lung.	911. Pneumothorax requires chest tube and hospital management. Do not attempt to manage this outside of emergency care.
Chronic respiratory damage (longer-term)	Chronic cough, increased sputum production, hemoptysis (coughing blood) in smaller amounts over time, reduced exercise tolerance — all signs of cumulative lung damage from repeated crack smoking.	Pulmonologist evaluation. Cessation of crack smoking. Lung function testing (spirometry) to assess the degree of damage. Some chronic damage is reversible with cessation; some is not. Assessment establishes the baseline.

Overdose Recognition in the Crack Context

Crack cocaine overdose presents primarily through cardiovascular and neurological events, but the specific crack context adds features that distinguish it from powder cocaine overdose:

- Hyperthermia — crack's intense sympathetic activation combined with physical activity can rapidly elevate body temperature to dangerous levels. Very hot, flushed, no longer sweating: 911 and cooling measures.
- Seizure — both from cocaine neurotoxicity and from the hyperthermia itself. Call 911. Recovery position. Do not restrain.

- Cocaine-induced psychosis — paranoid, extremely agitated, believing they are being followed or that people are trying to harm them. Remove from the environment to a calm, safe space. Call 911 if violence risk or severe disorientation.
- Overdose in the context of other substances — crack combined with alcohol creates cocaethylene (more cardiac toxic than either alone). Crack combined with opioids or benzodiazepines: the stimulant may mask opioid sedation; carry naloxone. Combination overdose requires 911 regardless.

Harm Reduction for Active Smoking — Safer Crack Use

THE CENTURION — For People Who Are Not Yet Ready to Stop — Reducing the Harm That Is Happening Now

This section is here because harm reduction saves lives even when recovery has not yet begun. The Recovery Kernel does not require abstinence before offering assistance. If someone is currently using crack and not yet ready to stop, the following harm reduction practices reduce the most acute risks:

- Glass pipes over improvised alternatives: brass chore-boy, aluminum can, or plastic pipe smoking produces additional toxic exposure beyond the cocaine itself. Glass pipes with rubber mouthpieces reduce burns to lips and hands and eliminate metal or plastic combustion byproducts.
- Mouthpiece use: a rubber or silicone mouthpiece prevents direct hot-glass contact with the lips, reducing the burns and cuts that create entry points for HIV and other bloodborne infections.
- Do not share pipes: the lip cuts and sores that develop with crack pipe use create bloodborne pathogen transmission risk equivalent to needle sharing. Do not share.
- Lip care: vitamin E oil or petroleum jelly on lips and around the mouth reduces the cracking and sores that develop with chronic pipe use.
- Fentanyl test strips: fentanyl has been found in crack cocaine supply. While crack is smoked rather than injected, fentanyl absorbed through pulmonary mucosa can produce respiratory depression. Test strips are available through harm reduction organizations.
- Never use alone: crack's cardiac and pulmonary emergency risk is highest in the immediate smoking window. Having someone present who can call 911 is life-saving.
- Naloxone: if crack is being used alongside opioids, or if supply contamination is a concern, carry naloxone. It does not harm someone who has not taken opioids but can save the life of someone who has.

Harm reduction kits for crack cocaine are available through local needle exchange programs and many public health departments in most major cities. These kits provide the materials above and are free.

Section 1 — What Crack Cocaine Did to Your Brain

THE CENTURION — Same Molecule, Different Delivery — How the Route Changes Everything

Crack cocaine and powder cocaine share an identical pharmacological mechanism: simultaneous blockade of the dopamine transporter (DAT), serotonin transporter (SERT), and norepinephrine transporter (NET). The molecule is the same. What is different — dramatically, architecturally, clinically — is how that molecule reaches the brain.

The cocaine guide in this series covers the core pharmacology: the triple reuptake inhibition, the Warrior COMT profile, the cardiovascular mechanisms, the binge-crash cycle, the genomic blueprint. Read it alongside this guide. The Biology of crack cocaine addiction is the biology of cocaine addiction with one variable changed — and that one variable changes everything.

1.1 — The Route Changes Everything: The Pharmacokinetics of Crack

Pharmacokinetic variable	Smoked crack cocaine	Intranasal powder cocaine
Time to peak brain concentration	6–10 seconds. The pulmonary capillary bed provides almost direct arterial access to the brain — the fastest possible delivery short of intra-arterial injection.	3–5 minutes. Intranasal absorption requires transit through nasal mucosa, systemic circulation, and the blood-brain barrier.
Peak effect intensity	The rush: an initial 10–20 second peak of extreme euphoria produced by the sudden massive dopamine flood. Qualitatively distinct from intranasal cocaine — more sudden, more total, more overwhelming. The specific neurological event whose memory drives the return.	Elevation: a slower-building, more sustained euphoria without the distinct initial rush peak. Still powerfully reinforcing, but different in character — more like a rising tide than a wave.
Duration of primary effect	10–15 minutes. The shortest duration of any cocaine administration route. By the time the rush has peaked, the effect is already declining.	20–30 minutes. Substantially longer, allowing longer intervals between doses in a binge.

Bioavailability	~70% pulmonary bioavailability when smoked correctly. High bioavailability combined with rapid delivery produces higher peak plasma levels than equivalent intranasal doses.	~60% intranasal bioavailability. Lower peak plasma levels at equivalent doses.
Addiction liability	The highest of any cocaine administration route. The combination of very fast onset + very high peak + very short duration produces the pharmacokinetic profile most associated with compulsive use and rapid dependence development.	High, but lower than smoked. The slower onset and longer duration allow more interval time between doses and less intense anticipatory craving between hits.
Crash intensity	Proportional to the peak. The higher the peak dopamine flood, the steeper the crash when it clears. The crack crash — the minutes after the rush fades — is among the most intense neurochemical deficits in stimulant use. The contrast with the rush is maximized, driving immediate re-dosing.	Significant but less acute. The more gradual onset means the clearing is also more gradual — the crash is less dramatic and less immediately compelling of re-dosing.

1.2 — The Rush: The Memory That Drives the Return

THE CENTURION — The Most Specific and Most Powerful Reinforcement Memory in the Stimulant Category

The crack rush is not simply 'very good cocaine.' It is a qualitatively distinct neurological event — the product of a bolus of cocaine arriving at the dopamine system in seconds, producing a sudden and overwhelming signal that the reward system has never encountered outside of the pipe.

The neuroscience of why this matters: the reinforcement learning system encodes the magnitude and speed of reward. The faster and more intense the reward, the more deeply it is encoded and the more powerfully the cue that preceded it is associated with the anticipation of its return. The crack rush encodes at the maximum possible depth because it is the maximum possible speed-and-magnitude combination the system has experienced.

This produces the specific craving architecture of crack recovery: the craving is not for cocaine in the abstract. It is for the rush specifically — the specific 10–20 second peak event whose memory is stored with exceptional vividness and whose associated cues fire with exceptional power. The cue that triggered the first hit before the first rush of a session fires this memory with the full intensity of the event itself.

Understanding this is the foundation of the craving interrupt protocol in Section 5. You are not managing a vague urge. You are managing a precisely encoded memory of a specific neurological event — and the craving is the prediction of that event's return.

1.3 — The Crack Binge: Shorter Cycles, More Extreme Consequences

THE CENTURION — The 15-Minute Clock That Runs the Binge

The cocaine guide describes the binge-crash cycle of powder cocaine. In crack, this cycle runs on a 10–15 minute timeline rather than a 20–30 minute one. The consequences of compressing the cycle:

- More doses per unit time: where an intranasal binge might involve 10–15 lines over several hours, a crack binge can involve 20–30 or more hits in the same period.
- More extreme dopamine depletion per session: more total doses means more total release and reuptake blockade, deeper D2 receptor downregulation, and a more severe post-binge crash.
- More money per session: the compulsion to re-dose every 10–15 minutes means far greater financial expenditure per binge than powder cocaine at equivalent street prices.
- More total cardiovascular stress: every hit produces a cardiovascular event — vasospasm, sympathetic activation, heart rate and blood pressure surge. Twenty hits in a night is twenty cardiovascular events.
- More total pulmonary exposure: the lungs process every hit. More hits per session means more total alveolar exposure to hot cocaine vapor.
- The pipe scraping: when supply runs out at the end of a binge, the impulse to scrape residue from the inside of the pipe — burning or re-burning material that was already partly combusted — is a specific feature of crack binges that compounds pulmonary toxicity.

1.4 — The Physical Markers: What Crack Use Leaves on the Body

Unlike intranasal cocaine (which leaves nasal damage) or IV cocaine (which leaves injection sites), smoked crack leaves its physical record in specific locations:

- Pipe burns: burns on the lips, fingertips, and the web of skin between thumb and forefinger from handling hot pipes. These are often dismissed but are both a physical harm and a cue — the healed burns become physical reminders with craving-triggering potential.

- Chronic cough and dark sputum: the residue from crack combustion accumulates in the respiratory system, producing a characteristic productive cough with dark-tinted sputum.
- Dental damage: crack cocaine's vasoconstriction reduces blood flow to the gum tissue and teeth. Combined with the dry mouth, bruxism (teeth grinding from stimulant effects), and poor nutrition during binge periods, dental damage is progressive.
- Weight loss: the appetite suppression of stimulant use is compounded by the financial priority of the drug over food during active use.
- Skin picking (formication): the tactile hallucination of 'coke bugs' — the sensation of insects under the skin — is more common with crack than intranasal cocaine due to higher peak plasma levels. The resulting skin picking lesions are both a physical harm and a cue in recovery.

1.5 — The Context: What the Crack Epidemic Did Beyond the Pharmacology

THE CENTURION — The Compendium Names What the Policy Did: Punishment Was Substituted for Medicine

The Recovery Kernel Compendium's historical timeline names the crack cocaine epidemic in a sentence that contains an indictment: 'Drug policy responses criminalized crack at 100:1 sentencing disparity vs. powder cocaine; disproportionate incarceration of Black communities; treatment infrastructure absent; punishment substituted for medicine.'

This guide does not leave that sentence behind after Section 1. It runs through every section because its consequences run through every person who was part of the crack epidemic — whether they used crack themselves, had a family member incarcerated, grew up in a community disrupted by both the drug and the enforcement response, or spent years inside a system that said 'five grams of crack = 500 grams of powder cocaine' under the law.

The Fair Sentencing Act of 2010 reduced the disparity from 100:1 to 18:1. The First Step Act of 2018 made this retroactive for some. Neither law has fully repaired what the disparity did. The barriers to recovery that the crack epidemic's criminal justice response created — records, restricted housing, restricted employment, interrupted family relationships, community-level trauma — are not historical. They are present in the lives of many people reading this guide.

The Recovery Kernel's position, stated plainly: the dependency that developed was biology. What happened to many people as a consequence of the dependency was a policy choice. The biology required medicine. The policy chose incarceration. The person who developed crack cocaine use disorder did not fail. They were failed — by a pharmacological trap that was allowed to flourish in communities already under structural pressure, and by a response that treated medicine as a crime.

Recovery in this context is not simply stopping the drug. It is rebuilding a life in conditions that the drug, and the response to it, complicated in ways that are not solved by neurochemistry alone. This guide addresses both.

Section 2 — Your Genomic Blueprint

The genomic profile for crack cocaine recovery is identical to powder cocaine — because the pharmacological mechanism is identical. The compendium's powder cocaine guide covers the genomic panel in full detail: COMT (Val/Val Warrior primary), DAT1/SLC6A3, DRD2/ANKK1, SLC6A4, MTHFR, DRD4, BDNF, CYP3A4.

This section provides the crack-specific interpretation of those genes — what they mean when the route is smoked rather than insufflated.

Crack-Specific Genomic Considerations

Gene	Crack-specific interpretation	Recovery implication
COMT Val158Met	Val/Val (Warrior) is the primary crack vulnerability profile — same as powder cocaine. The fast dopamine clearance that makes the Warrior baseline flat makes the sudden, enormous crack rush even more dramatically contrasting with the baseline. The Warrior brain has been seeking the intensity that crack delivers with unmatched efficiency.	Warrior recovery architecture: genuine high-intensity natural dopamine must be the recovery target. Low-intensity recovery environments will not hold the Warrior's engagement. This is not a preference — it is a physiological requirement.
DRD2 / ANKK1 Taq1A	A1 allele (reduced D2 density) combined with Val/Val COMT creates a dual-deficit Warrior profile that crack addresses with devastating efficiency. The D2 deficit means the reward system was always 'not enough' at baseline. The rush is the first time it was ever 'enough.'	The Brain Stack (UMP + DHA + CDP-Choline) for D1/D2 receptor upregulation is highest priority for the double-deficit profile. Building receptor density is the structural recovery target alongside dopamine precursor support.
DAT1 / SLC6A3 (10-repeat)	The dopamine transporter is the primary target of cocaine's mechanism — and crack's smoked delivery floods the DAT with cocaine before the transporter can adapt. DAT1 10-repeat (high DAT expression) means more rapid baseline dopamine clearance — making the crack hit's DAT blockade even more pharmacologically dramatic relative to baseline.	The ADHD association of DAT1 10-repeat is particularly relevant in crack recovery: the cognitive clarity that crack provided may have been ADHD self-medication. ADHD evaluation in early recovery can identify whether non-stimulant ADHD treatment would address a genuine underlying condition.
MTHFR	MTHFR variants affect dopamine	5-MTHF is often transformative in

	synthesis efficiency. For crack users with MTHFR impairment, the baseline dopamine deficit was partly a methylation problem — and the crack rush was filling a biological hole that methylation support could address through safer means.	crack recovery for MTHFR variant carriers — directly addressing the synthesis deficit that crack was compensating for. This may be the most impactful single supplement.
BDNF Val66Met	Crack cocaine's higher-peak dopamine floods produce more significant BDNF suppression in the prefrontal cortex than intranasal cocaine at equivalent total doses — because the bolus nature of crack delivery creates more intense peak suppression. Met carriers with reduced baseline BDNF face compound suppression.	Exercise is non-negotiable for BDNF recovery from crack. The cognitive fog, decision-making impairment, and impulsivity of crack recovery require BDNF-driven prefrontal cortex repair. Exercise is the fastest available BDNF driver. Begin immediately.
CYP3A4 and CYP2D6	Smoked crack delivers a bolus that largely bypasses first-pass metabolism — the liver does not filter the initial hit because the drug goes directly from lungs to arterial circulation. CYP3A4 metabolizes crack cocaine after this arterial distribution, but the initial pharmacological event is almost entirely pre-metabolic.	This means that CYP3A4 inhibitors (fluconazole, grapefruit, certain antibiotics) affect the duration of crack's effects more than the intensity of the initial rush — because the rush occurs before hepatic metabolism. Drug-drug interactions remain relevant but shift in profile compared to intranasal cocaine.

Phenotyping in the Crack Context

- Did crack feel like the first time everything was as it should be — intensity, aliveness, full signal? → Classic Warrior COMT + DRD2 A1 double-deficit profile. The biological basis of recovery architecture is clear.
- Did you use crack for focus or productivity before the dependence deepened? → DAT1 10-repeat + DRD4 7-repeat ADHD profile. ADHD evaluation is a recovery priority.
- Did the crash from crack feel more devastating than the crash from other stimulants you've used? → This is the pharmacokinetic consequence of the higher peak — the Warrior brain crashes harder from higher peaks. The proportionality is expected.
- Did you develop significant respiratory symptoms — chronic cough, shortness of breath, coughing blood — during heavy use? → Pulmonary evaluation is a medical priority regardless of how much time has passed since last use.
- Do you have a family history of cardiac disease and were using crack heavily? → Cardiovascular evaluation with ECG and cardiac enzyme testing is appropriate, particularly if any cardiac symptoms occurred during use.

Section 3 — The Crash: The Most Severe Dopamine Floor in the Stimulant Category

THE CENTURION — Proportional to the Peak — and the Peak Was Total

Crack cocaine withdrawal — specifically the crash that follows a heavy smoking binge — is the most severe acute dopamine floor in the stimulant category. The principle is pharmacokinetic: the height of the dopamine peak determines the depth of the crash when the receptor blockade clears.

Crack's peak is the highest of any cocaine administration route. The crash is correspondingly the deepest. The person who smoked heavily through the night enters the post-binge crash state — sometimes called 'the bottom' in crack culture — in a state of neurobiological devastation that is qualitatively different from the cocaine comedown. The depression is total. The anhedonia is complete. The craving for the pipe is immediate and overwhelming. And the physical exhaustion of a night of cardiovascular stress, no food, no sleep, and constant sympathetic nervous system overdrive compounds everything.

3.1 — The Post-Binge Crash Timeline

Phase	Biology	Experience	What to do
The immediate crash (Hours 0–4)	Dopamine and norepinephrine depleted across all release sites; D2 receptors at maximum downregulation; the sustained cardiovascular assault of the binge has left the sympathetic nervous system temporarily exhausted	Extreme fatigue, profound depression, intense craving for the pipe, possible paranoia, physical shaking, sweating, chest tightness, extreme hunger or complete appetite loss, inability to feel any pleasure	The crash itself is not medically dangerous in most cases — but the cardiovascular stress of the binge may have been. If any chest pain or respiratory symptoms are present: 911 before anything else. Otherwise: Protocol 01. Lie down. Drink water. Eat if possible. Do not use.
The hypersomnia phase (Hours 4–24)	The physical system demands repair time. Sleep is not optional — it is the primary mechanism of dopamine resynthesis and glycogen restoration after the binge.	Overwhelming need to sleep. Difficulty staying awake even while wanting to use. Vivid dreams or disturbing sleep. Waking still feeling depleted.	Sleep. This is not failure. This is physiology. The compendium names this for stimulant withdrawal: 'the system is in low power mode.' The sonic protocol is 60–80 BPM, warm textures — not fighting the crash with stimulating input.

The vulnerable window (Days 2–7)	D2 receptors beginning to recover but still significantly downregulated. Dopamine levels below baseline. BDNF suppressed. Any environmental cue from the crack context fires the rush memory at full intensity.	Better than the immediate crash but still significantly anhedonic. The world is gray. Nothing is interesting. The pipe is remembered vividly. Social isolation common. Sleep disrupted. Cravings episodic and intense.	Full supplement protocol begins. Exercise starts — even brief. Environmental redesign is the most important behavioral intervention in this window. Remove or avoid every identifiable crack-associated cue. Contact your support structure.
Weeks 1–4 (the slow recovery)	D2 receptor density measurably recovering. Dopamine synthesis capacity rebuilding. BDNF responding to exercise and novel stimulation. Serotonin recovering from the SERT component.	Gradual improvement with significant daily variability. Crack cravings triggered by specific cues — sounds, places, people, smells — with high intensity and speed. The rush memory fires from cues that may seem unrelated to use.	PAWS management is the central task. Document every craving with its trigger. Execute the interrupt protocol every time. Build the natural reward architecture — it is the only sustainable alternative to the pipe.
Months 1–12	Significant D2 recovery. Dopamine and serotonin systems rebuilding. BDNF at or approaching baseline with exercise. Cognitive function recovering.	Episodic cravings, primarily cue-triggered. Genuine pleasure slowly returning. Motivational drive improving. Identity work beginning.	The natural intensity architecture from Section 6 becomes increasingly available and effective. The Warrior brain is finding what it always needed — through means it owns.

3.2 — Medical Assessment in Early Recovery

Unlike most stimulant recovery, crack cocaine recovery warrants specific medical assessment beyond the standard metabolic and cardiovascular evaluation because of the pulmonary route of administration:

- Pulmonary function testing (spirometry): assesses lung capacity and the degree of airway damage from crack smoking. Establishes baseline. Some damage is reversible with cessation; understanding the extent motivates and guides recovery.
- Chest X-ray or CT: if any respiratory symptoms are present, imaging evaluates for residual crack lung injury, pneumothorax, or chronic pulmonary changes.

- Cardiac evaluation: ECG for arrhythmia or ischemia evidence; blood pressure assessment. Echocardiogram if any cardiac symptoms occurred during use.
- Levamisole assessment (CBC): the same agranulocytosis risk from levamisole-contaminated cocaine supply documented in the cocaine guide applies to crack — the powder cocaine from which crack is made carries the same contamination.
- Dental assessment: crack cocaine-associated dental damage is often severe and requires dental evaluation. Dental access is a barrier for many in the crack recovery population — community health clinics and dental schools provide lower-cost options.
- Nutritional assessment: binge periods often involve severe nutritional neglect. Magnesium, zinc, B-vitamins, and protein are the priority replenishments.

Section 4 — Biological Reconstruction

The biological reconstruction protocol for crack cocaine is the cocaine guide's protocol — applied with adjustments for the more severe depletion profile of the smoked route. The deeper crash and more complete depletion require the same supplement foundation but with the understanding that recovery timelines may be longer and that the pulmonary system requires its own support.

4.1 — The Methylation Foundation

From the cocaine guide, applied with crack-specific emphasis:

Supplement	Dose	Timing	Crack-specific notes
5-MTHF (L-methylfolate)	400–1000mcg daily	Morning with food	The triple monoamine synthesis support (dopamine, serotonin, norepinephrine) is the same as powder cocaine. The crack-specific addition: MTHFR variants are also relevant to respiratory epithelial repair — the folate-dependent cell turnover that rebuilds lung lining after crack exposure is supported by adequate methylation. 5-MTHF serves both recovery targets simultaneously.
Methylcobalamin (B12)	1000–2000mcg sublingual	Morning	Crack binge patterns involve extended periods of poor nutrition. B12 depletion compounds the neurological recovery challenge. Sublingual methylcobalamin bypasses any GI absorption issues from nutritional neglect during crack use periods.
P5P (active B6)	25–50mg	Morning	Cofactor for all three monoamine synthesis pathways. The triple depletion of the crack binge — dopamine, serotonin, norepinephrine simultaneously — places maximum demand on P5P-dependent enzymes. Use pyridoxal-5-phosphate form exclusively.
Magnesium	400–600mg	Morning and	Crack cocaine significantly

glycinate	elemental	evening	depletes magnesium through metabolic and sympathetic mechanisms. Magnesium also reduces cardiovascular hyper-reactivity — relevant given crack's documented cardiac risk. Begin on Day 1 of recovery.
Zinc	20–30mg daily	Evening with food	Dopamine synthesis and immune function support. Crack binge periods involve near-total nutritional neglect — zinc is among the first minerals depleted. Also supports the immune function relevant to respiratory recovery from crack lung injury.

4.2 — Dopamine Reconstruction — The Primary Recovery Target

From the cocaine guide (full detail there), abbreviated and crack-adjusted here:

- L-Tyrosine (500–2000mg, morning, away from protein): dopamine precursor. The Warrior brain's central reconstruction support. Start at 500mg and titrate based on response and tolerance.
- Mucuna pruriens (100–300mg L-DOPA equivalent, morning): natural L-DOPA. More direct and faster-acting than tyrosine. Choose Mucuna OR tyrosine as primary — not both at maximum dose.
- Brain Stack — Uridine (250–500mg) + DHA (1g) + CDP-Choline (250mg): D1/D2 receptor density upregulation. The most important structural recovery target — rebuilding the receptor density that the crack binge repeatedly hammered down. This takes weeks to months. Begin on Day 1.
- NAC (600–1800mg daily, divided, with food): glutamate homeostasis in the nucleus accumbens. Multiple clinical trials specifically in cocaine use disorder. Begin immediately. The compendive craving-reduction evidence for NAC is the strongest of any supplement in this guide.
- Rhodiola rosea (300–600mg, morning): dopamine modulation; adaptogen; anti-fatigue. Weeks 2–8 when the flatness is prominent but the precursor stack alone is not yet sufficient.

4.3 — Serotonin Reconstruction — The SERT Component

Crack cocaine's SERT blockade depletes serotonin alongside dopamine — the same secondary reconstruction target as powder cocaine. The social ease and confidence of crack's initial effects included a serotonergic component that will be absent in recovery.

- 5-HTP (50–150mg, evening): serotonin precursor. Supports mood and sleep simultaneously. Do not combine with SSRIs.
- Inositol (4–12g, divided, titrate): serotonin receptor sensitivity modulation. Anti-anxiety with evidence for OCD and compulsive elements — relevant to crack's compulsive craving architecture.
- Omega-3 EPA-dominant (2–4g daily): EPA for mood; DHA for membrane fluidity and receptor function. Start immediately.

4.4 — Pulmonary Recovery Support

THE CENTURION — The Lungs That Absorbed Every Hit Must Also Be Rebuilt

Pulmonary recovery from crack smoking requires specific support beyond the standard cocaine recovery protocol. The lung is a direct primary target of crack's toxicity — unlike the nose (powder cocaine) or arm veins (IV cocaine), the lung absorbed every hit directly.

Supplement	Dose	Timing	Pulmonary recovery notes
NAC (included above — pulmonary specific emphasis)	600–1800mg daily	Morning and evening	NAC is a mucolytic — it breaks down mucus in the respiratory tract, reducing the chronically thickened mucus layer that crack smoking produces. This is NAC's additional pulmonary mechanism beyond its glutamate-homeostasis craving-reduction role. Both functions are simultaneously relevant for crack recovery.
Vitamin C	1000–2000mg daily	Morning and noon	Antioxidant directly relevant to pulmonary tissue recovery. Crack smoke produces significant oxidative stress in pulmonary tissue — vitamin C provides direct antioxidant protection and supports connective tissue repair in the alveolar walls. Also reduces the inflammatory component of residual crack lung injury.
Vitamin E (mixed tocopherols)	400 IU	With food, morning	Fat-soluble antioxidant protecting pulmonary cell membranes from lipid peroxidation from crack combustion products. Mixed tocopherols provide broader coverage than alpha-tocopherol

			alone.
Quercetin	500–1000mg daily	Morning	Anti-inflammatory flavonoid with specific evidence for respiratory mucosal protection and bronchial smooth muscle support. Particularly relevant for chronic bronchitis symptoms from crack smoking. Also has mild zinc-ionophore properties, enhancing zinc's immune support.
Saline nasal irrigation	Daily use	Morning	Although crack's primary route is pulmonary, upper respiratory tract involvement is also present. Daily nasal saline rinse (NeilMed or neti pot) supports upper airway mucosal recovery and clears retained crack combustion residues from the nasal and pharyngeal passages.

Pulmonary rehabilitation: if significant lung function impairment is identified on testing, formal pulmonary rehabilitation — supervised breathing exercises, aerobic conditioning — improves function and supports recovery. Available through hospital pulmonology departments and community health programs.

4.5 — Sleep Reconstruction in the Crack Context

Crack binges produce the most severe acute sleep deprivation of any cocaine pattern — 24–48 hour waking periods during binges, followed by crash hypersomnia, creating a severely disrupted circadian architecture. The sleep protocol is the same as the cocaine guide's but with emphasis on the longer recovery timeline for severe disruption:

- Melatonin: 0.5–1mg sublingual, 30 min before target sleep time. Circadian reset.
- Magnesium glycinate: 400mg evening. GABA support; anxiety reduction for sleep onset.
- Glycine: 3–5g, 30 min before bed. Core body temperature reduction.
- 5-HTP: 50mg evening. Serotonin-melatonin conversion.
- Epitalon (peptide — physician discussion): pineal pathway and circadian normalization — particularly relevant for the extreme circadian disruption of crack binge-crash cycles.

The compendium's stimulant withdrawal sonic protocol for sleep: delta binaural beats (0.5–4 Hz); 60–70 BPM maximum; ambient, drone, warm acoustic textures. No sudden dynamics. Low volume. The crack-specific addition: avoid music with strong

beat drops or tempo changes — these activate the associative arousal circuits that crack primed.

4.6 — Peptide Support Layer

Peptide	Why it matters for crack recovery specifically	Timing	Notes
BPC-157	Dopamine AND serotonin system modulation (addressing both triple-reuptake components); gut-brain axis repair from nutritional neglect; pulmonary tissue repair effects documented in animal models of respiratory injury; neuroprotection	Day 1 post-cessation — daily	BPC-157's pulmonary tissue repair properties make it specifically more relevant in crack recovery than in intranasal cocaine recovery. Its documented effects on wound healing and inflammatory tissue repair may support recovery of crack-damaged pulmonary mucosa. Oral form appropriate.
Semax	BDNF upregulation — crack cocaine's higher-peak dopamine flooding produces more severe prefrontal BDNF suppression than intranasal cocaine. Semax's BDNF-stimulating effects directly address this. Cognitive repair; dopamine and serotonin modulation.	Week 1 onwards	The cognitive impairment of crack recovery — impulsivity, poor working memory, difficulty with complex planning — reflects prefrontal BDNF suppression. Semax combined with exercise produces additive BDNF effects. The combination is the most efficient available approach to the cognitive component of crack recovery. Intranasal.
Selank	GABA and serotonin modulation; non-addictive anxiolytic; reduces the hypervigilance and paranoia that crack's norepinephrine surge produces and that can persist into early recovery	Weeks 1–8 as needed	Crack-induced paranoia (the suspicion, hypervigilance, and anxiety of high-dose smoked cocaine) can persist as an anxiety residue in early recovery — particularly in the first weeks before the norepinephrine system normalizes. Selank addresses this without addiction liability.
Epitalon	Circadian normalization; sleep architecture;	Weeks 1–4	The circadian devastation of crack binge-crash cycles is

	telomere protection — the extreme sleep deprivation of crack binges produces measurable telomere shortening through cortisol-mediated mechanisms		among the most severe in stimulant use. Epitalon directly supports the pineal pathway and circadian reset.

Section 5 — The Crack Craving — Understanding and Interrupting

THE CENTURION — The Most Specific and Fastest-Firing Craving in the Stimulant Category

Crack cocaine cravings have a specific character that distinguishes them even from powder cocaine cravings. They are faster — triggered in milliseconds by cues that the brain associates with the pipe. They are more specific — not a general dopamine want but a precise anticipatory prediction of the rush. And they carry a specific physical quality — a constriction in the chest, a rush of heat, an almost-taste — that is the brain preloading the sensory experience it predicts is coming.

The compendium's principle applies directly: 'my amygdala is generating a conditioned craving signal.' Name it with clinical precision. The rush that the brain is predicting is a dopamine event — a specific, measurable neurological occurrence. The craving is the prediction. The interrupt is providing a counter-prediction before the first prediction completes.

The Crack-Specific Craving Triggers

Trigger	Why it is so powerful	The interrupt
The pipe itself (or any similar object)	The pipe is the most directly conditioned cue — it was the object immediately preceding every rush. The sight of a pipe, or any similar cylindrical glass or metal object, fires the rush prediction at near-full intensity through direct visual cue conditioning.	Environmental redesign (Protocol 05) removes this cue from the home environment completely. Outside the home: immediate aversion of gaze and environment change. Do not handle the cue. Physical exit before cognitive processing.
The sound of the lighter	Auditory conditioning: the specific sound of a lighter flicking was paired with the seconds before the rush thousands of times. This sound can fire the rush prediction as powerfully as visual cues — and is encountered in ordinary life constantly (smokers, candles, stoves).	This cue cannot be fully avoided — lighters are everywhere. The response: name it immediately ('that sound fired a craving'), execute 4-7-8 breathing immediately, move away from the source. The auditory craving fires fast and fades fast — the key is responding before it escalates.
The smell of smoke	Olfactory memory is among the most strongly conditioned of any sensory modality — smell bypasses the cortex and	Move away from the smell if possible. Name the trigger. Execute 4-7-8. L-theanine 200mg. Contact support. The

	projects directly to limbic regions where the craving memory is stored. Any smoke smell — cigarettes, fires, incense — can activate crack craving through cross-modal conditioning.	compendium names phantom smell as a documented recovery phenomenon — sometimes the smell arises internally from memory rather than any external source. Same protocol.
Specific locations — corners, buildings, neighborhoods	Place-based conditioning is among the most powerful and least avoidable of crack's cue architecture. The specific corner, building, alley, or neighborhood where crack was obtained or used fires the craving with full geographical specificity.	Protocol 05 (environmental redesign) must address geography. Some recovery from crack requires relocating — not always possible, but where possible, one of the most impactful interventions. Where relocation is not possible: route planning that avoids the highest-risk locations is the harm reduction approach.
Money in hand — particularly specific denominations	The sequence leading to crack purchase was: money in hand → purchase → pipe → rush. Money itself becomes a conditioned cue that fires the anticipatory sequence. Specific denominations associated with crack purchase amounts carry the strongest conditioning.	Automated bill payment and direct deposit with spending restriction during early recovery reduces cash handling. If cash is in hand and craving fires: immediately put money away, execute the interrupt protocol, contact support. Do not be near the source of supply with cash in hand in early recovery.
The crash state itself — the deepest moment of the come-down	The bottom of the crash — the most complete anhedonia, the deepest depression — is when the craving for the pipe is most overwhelming. The brain's solution to 'this is unbearable' is the fastest thing it knows that makes it bearable: the pipe.	This is the highest-risk craving state and requires the most robust response. Medical support contact if the crash is severe. Support person with you during the crash window if possible. 988 crisis line available. The supplement stack provides biological support. The compendium's Protocol 01 was built for exactly this state.

THE CRACK CRAVING INTERRUPT — 5-MINUTE PROTOCOL

1. MOVE FIRST, THINK SECOND. Before any cognitive processing: change your physical environment and position immediately. Walk away from whatever triggered the craving before executing any other step. The craving requires the cue environment. Remove yourself from it.
2. HIGH-INTENSITY PHYSICAL INTERRUPT. The crack craving fires at maximum voltage — it requires a maximum-intensity counter-signal. Sprints, jumping jacks, push-ups, cold water on the face, anything that creates an overwhelming immediate physical sensation that competes with the craving signal. Not optional. Not too hard. Required.

3. EXECUTE 4-7-8 BREATHING — SIX CYCLES. The Warrior brain that just experienced a full-intensity rush prediction needs the vagal brake engaged. Six cycles, not four. The additional cycles matter for the intensity of the crack craving signal.
4. NAME IT CLINICALLY. Say out loud or write: 'My dopamine anticipation circuit fired because [specific cue]. This is a conditioned craving signal, not a command.' The compendium's precision language principle: naming the mechanism interrupts the mythology. The craving is not the pipe calling. It is the amygdala generating a prediction. The prediction can be interrupted.
5. TAKE NAC AND TYROSINE. The glutamate homeostasis (NAC) and dopamine precursor (tyrosine) address the neurochemical urgency. The craving has a biological substrate. The supplement addresses it directly.
6. CONTACT. One call or text to your support structure. Name what triggered it. Name what you are doing. Connection is the counter-substance — the social dopamine signal that partially interrupts the crack craving's circuit. You do not need rescue. You need signal.
7. EXECUTE YOUR HIGHEST-INTENSITY NATURAL REWARD. From Section 6: vigorous exercise, competition, creative work, cold exposure — anything genuinely intense. The Warrior craving requires a real-intensity response. Inadequate natural reward does not meet the threshold. It must be real.

Section 6 — Porting the Addiction: The Warrior's Intensity Architecture

THE CENTURION — The Engine That Chased the Pipe Is the Same Engine That Wins Anything It Points at

The cocaine guide says it for the Warrior, and it applies here with even more direct force: the crack cocaine user was not looking for a gentle enhancement. They were looking for a signal loud enough to break through the silence that the Warrior baseline produces. The rush was the loudest signal available. The recovery is finding signals that are loud enough to matter — to actually reach the threshold of a nervous system that cleared dopamine before most substances could generate it — through means that do not also destroy the lungs and the heart.

The compendium's Centurian Paper C-28 applied to crack recovery: the Olympian of Nothing who spent nights in the pipe's orbit is the same person who, with the right address, would pursue mastery with exactly that intensity. The chase instinct does not go away. The pipe did not create it. Recovery is finding what the chase was always for.

The Natural Intensity Architecture — What Meets the Warrior Threshold

Natural reward source	Dopamine intensity	How to build it	For crack recovery specifically
High-intensity exercise — especially sprints and combat sports	Very High — the most immediate and reliable natural dopamine source	Daily. Running sprints, boxing, wrestling, CrossFit, martial arts. The intensity must be genuine — moderate exercise does not reach the Warrior threshold. Maximum effort sessions.	The Warrior brain that chased crack through the night has precisely the intensity and endurance disposition that makes elite physical training natural. The pain of hard training — the lactate burn, the oxygen debt — is familiar territory for a nervous system accustomed to the crash. Direct this energy. The physical rebuilding of the body damaged by crack use (pulmonary, cardiovascular, nutritional) and the natural dopamine generation happen simultaneously.
Competition — any domain with genuine stakes	Very High — social stakes amplify dopamine 3–	Competitive sport, martial arts combat, competitive gaming, sales competition,	The crack rush had a specific social quality — it happened in a specific place, often with specific people, with money changing

	5x beyond solo achievement	bodybuilding shows, boxing matches, anything where losing is real.	hands. The competitive stakes of a real contest provide the social-stakes dopamine through a channel the Warrior was built for. Enter something. Train for it. The preparation is the practice of the recovery architecture.
Mastery and skill development — at the edge of competence	High — escalating mastery provides sustained dopamine over months and years	Music, welding, woodworking, coding, graphic design, any craft that can be continuously developed. The key: it must always be slightly beyond current capability.	The compendium's flow architecture applies: 'challenge at four percent beyond current skill.' The Warrior who could chase crack through a 24-hour binge can sustain the focused attention required for genuine mastery — with the same endurance, directed differently. Mastery produces identity, income, and dopamine simultaneously.
Service — specifically to others navigating crack recovery	High — sustained; the oxytocin, meaning, and dopamine of genuine contribution	Peer recovery support, mentorship, community organizing, advocacy. Being the person who understands the specific territory — the pipe, the crash, the neighborhood, the legal system aftermath — for someone else who is in it.	The person who has survived crack cocaine use disorder and the criminal justice system's response to it has specific lived knowledge that no textbook produces. As a peer recovery supporter, this knowledge is the most valuable available resource for someone currently in the territory. The role provides purpose, contribution, and the social dopamine of genuine connection — through means the nervous system owns.
Financial recovery — building economic security	High — sustained; financial security activates both safety and achievement systems	Budgeting, debt reduction, financial literacy, employment or entrepreneurship — the specific tools of economic rebuilding after the financial devastation of crack addiction.	Crack cocaine is uniquely economically devastating because of the frequency of re-dosing. A crack binge can cost hundreds or thousands of dollars in a single night. The financial wreckage — debt, stolen property, lost employment, incarceration's economic aftermath — is often among the most concrete harms to address in recovery. Financial recovery is not separate from the recovery architecture — it IS part of the architecture. Every dollar saved, every debt reduced, is a genuine dopamine event for the Warrior brain that values concrete achievement.

Section 7 — Navigating the Recovery Kernel: Your Protocol Map

The crack cocaine recovery protocol map is the cocaine protocol map with specific additions for the pulmonary dimension, the criminal justice barrier management, and the more extreme binge-crash recovery timeline.

Phase	Protocols	Primary focus	Crack-specific notes
Medical Assessment (Days 0–7)	Physician; pulmonologist if symptoms; cardiologist if indicated; CBC for levamisole	Pulmonary function; cardiac evaluation; levamisole CBC; dental assessment; nutritional status	Pulmonary assessment is the crack-specific addition to the standard cocaine medical protocol. If any respiratory symptoms are present — cough, shortness of breath, coughing blood — pulmonology evaluation is urgent, not deferred. Crack lung injury is partly reversible if caught early.
Biological Foundation (Days 1–14)	Protocol 07, Protocol 09, Protocol 17, Protocol 18	Triple supplement stack (dopamine + serotonin + pulmonary); sleep; nutrition; crash management	NAC on Day 1 — it serves triple duty in crack recovery: craving reduction (glutamate homeostasis), pulmonary support (mucolytic), and antioxidant. Brain Stack, tyrosine, 5-MTHF, magnesium, vitamin C and E (pulmonary antioxidant) all begin Week 1. The crash management protocol from Section 3 runs throughout this phase.
Environmental Redesign (Weeks 1–4)	Protocol 05 (geographic + digital + social)	Cue removal; geographic redesign; social network redesign; pipe disposal	Crack's cue architecture is geographically specific in a way that powder cocaine is not — the corner, the building, the neighborhood are powerful cues that require active management. Where relocation is not possible, route planning and schedule redesign that avoids the highest-risk geographic cues is the harm reduction approach.
Criminal Justice Navigation (Weeks 1–12, ongoing)	Section 8 of this guide; legal aid; drug court; expungement resources	Probation/parole compliance; drug court if applicable; expungement eligibility assessment; housing and employment navigation with criminal record	Many people in crack recovery are simultaneously navigating probation, parole, drug court, or the aftermath of prior incarceration. Protocol 13 (Physician Conversation) extends to: the legal system conversation. Drug court is a recovery resource — not only a legal requirement. Public defender and legal aid organizations can

			advise on expungement eligibility.
Genomic Mapping (Weeks 1–4)	Section 15 (Compendium); COMT, DRD2, MTHFR, DAT1, BDNF	Constitution assessment; RDS scoring; methylation; ADHD markers	COMT Val/Val + DRD2 A1 is the highest-vulnerability double-deficit Warrior profile — identifying it determines the recovery architecture direction. ADHD evaluation if DAT1 10-repeat + DRD4 7-repeat are likely: this profile has been using crack as ADHD self-medication and non-stimulant treatment can address the genuine underlying condition.
Intensity Architecture (Weeks 2–12)	Protocol 03 (exercise), Section 6 of this guide	High-intensity exercise daily; competition identification; mastery development; service beginning	The Warrior cannot wait months for the intensity architecture to be built. Begin in Week 2 while still in the crash recovery period — even brief, low-intensity movement is BDNF and the foundation of what comes. The intensity architecture builds progressively. By Month 3, the natural reward system must be generating genuine signal or the pull back to the pipe will remain biologically compelling.
Identity and Economic Work (Months 2–12)	Protocol 20, Protocol 21, C-28; financial literacy; employment support	Identity beyond crack; economic rebuilding; the Warrior's legitimate professional expression	The identity work for crack recovery has a specific economic dimension that few other recovery guides carry. The crack epidemic's criminal justice response created structural economic barriers (records, restricted housing, employment discrimination) that are real barriers to identity reconstruction. Addressing these barriers is part of the recovery work.
Long Game (Months 6+)	Protocol 24, Protocol 25, C-28; peer recovery support	The Warrior's full intensity in a life the pipe did not build; service to others in the same territory; the evidence that recovery is possible	The person at six months or a year of crack cocaine recovery who has rebuilt their physical health, developed the intensity architecture, navigated the legal aftermath, and begun service — is a profound proof of concept for everyone still in the territory. That proof of concept is the purpose of the long game.

Section 8 — The Medical and Systemic Context

8.1 — Medical Priorities Specific to Crack

- Pulmonary function testing: spirometry at baseline, 3 months, and 6 months. Understanding the trajectory — whether lung function is improving, stable, or declining — informs both clinical management and recovery motivation.
- Cardiovascular: ECG, blood pressure monitoring, cardiac enzyme testing if any symptoms occurred during use. Echocardiogram for significant use history or any symptoms.
- Levamisole: CBC at baseline and 1 and 3 months. The agranulocytosis risk from levamisole-contaminated cocaine supply is present for crack users because crack is made from the same powder supply.
- Dental: comprehensive dental assessment. Crack cocaine dental damage can be severe. Community health centers, dental schools, and sliding-scale dental practices provide options when cost is a barrier.
- Nutritional status: protein, magnesium, zinc, B-vitamins, vitamin C assessment. Binge periods typically involve severe nutritional neglect. Nutritional repletion supports every other recovery system.
- Reproductive health: for women, crack cocaine use during pregnancy is associated with adverse neonatal outcomes. If pregnancy is possible, prenatal care and obstetric support should be arranged early.

8.2 — Navigating the Criminal Justice System in Recovery

THE CENTURION — The System That Chose Punishment Owes You Nothing — But Some of Its Tools Are Now Recovery Resources

For people whose crack cocaine use disorder intersected with the criminal justice system — through arrest, prosecution, incarceration, or ongoing probation and parole supervision — the legal landscape is part of the recovery landscape. This section provides the navigation framework.

Drug court: Many jurisdictions offer drug court as an alternative to incarceration for drug-related offenses. Drug court programs typically involve: frequent court appearances, drug testing, treatment participation, and graduated sanctions and rewards based on compliance. Completion of drug court typically results in reduced or dismissed charges. Drug court is simultaneously a legal requirement and a recovery support structure — the accountability it provides can be genuinely useful, not merely punitive.

Probation and parole compliance: Drug testing in probation and parole creates accountability that, framed correctly, supports recovery rather than simply punishing use. Inform your probation or parole officer of your recovery engagement — treatment participation, medical appointments, and support group attendance are typically viewed favorably and may provide flexibility within the supervision structure.

Expungement eligibility: The First Step Act of 2018 made the reduced crack-powder sentencing disparity retroactive for some federal convictions. State expungement laws vary significantly. Legal aid organizations and public defenders can assess whether prior convictions are eligible for sentence reduction, expungement, or sealing — which affects housing applications, employment background checks, and access to education.

Housing with a record: Criminal records create barriers to many conventional housing programs. Fair Chance Housing ordinances (passed in several major cities) restrict landlord use of criminal records in housing decisions. Section 8 housing vouchers and HUD public housing policies have their own criminal record restrictions — legal aid can advise on eligibility. Recovery residences (sober living homes) typically accept people with criminal records and provide housing support specific to recovery.

Employment with a record: Ban the Box laws (passed in many states) restrict employers from asking about criminal history on initial job applications — creating a fairer opportunity to demonstrate qualifications before the record is disclosed. Second-chance employment programs specifically serve people with criminal records. Vocational rehabilitation services, job training programs, and workforce development centers are available in most metropolitan areas.

8.3 — Medications for Crack Cocaine Recovery

Same as powder cocaine — no FDA-approved medication specifically for crack or cocaine use disorder. The emerging options:

- Bupropion (Wellbutrin): dopamine and norepinephrine reuptake inhibition; evidence for cocaine craving reduction; addresses the depression component. CYP2B6 metabolized — slow metabolizers accumulate at higher levels.
- Modafinil/Armodafinil: wakefulness agent with DAT modulating properties; evidence for cocaine craving and cognitive recovery; non-stimulant with low abuse liability.
- Naltrexone: modest evidence for crack craving reduction through opioid system modulation; more evidence for alcohol co-use disorder; OPRM1 A118G variant shows strongest response.
- GLP-1 agonists (semaglutide, tirzepatide): emerging data for cocaine use disorder through reward circuit dampening. The most promising emerging pharmacological option. Discuss with physician.

- Non-stimulant ADHD treatment (atomoxetine, guanfacine, viloxazine): if ADHD co-occurs — addresses the DAT1/DRD4 deficit that crack was self-medicating. One of the most clinically impactful medical interventions when ADHD is confirmed.

8.4 — Community Resources Specific to Crack Recovery

- Crack-Cocaine Anonymous: CA meetings provide peer support from people who specifically understand crack cocaine use disorder. Find meetings at ca.org.
- SMART Recovery: evidence-based, non-12-step alternative. Tools for managing cravings, building motivation, and addressing the cognitive dimensions of recovery. Meetings available online and in person.
- Harm reduction organizations: local needle exchanges and harm reduction programs typically provide crack pipe kits, naloxone, STI testing, and navigation to treatment services without judgment.
- Reentry programs: for people leaving incarceration, reentry programs provide housing navigation, employment assistance, legal aid, and treatment connection. National Reentry Resource Center (nationalreentryresourcecenter.org) provides state-by-state resources.
- Crisis: 988 (Suicide and Crisis Lifeline) | 911 for medical emergencies | SAMHSA 1-800-662-4357

A Final Word

THE CENTURION — The Punishment Was Not What You Needed. This Is.

The compendium's historical timeline names what happened plainly: 'Drug policy responses criminalized crack at 100:1 sentencing disparity vs. powder cocaine; disproportionate incarceration of Black communities; treatment infrastructure absent; punishment substituted for medicine.'

The person reading this guide may have experienced that substitution directly — as incarceration, as a criminal record that followed them through housing applications and employment interviews, as a parent taken from the home by the criminal justice response to a biological dependency, as a community that watched punishment deployed while medicine was absent.

The Recovery Kernel was built for the people who ran out of time before anyone told them their biology was not their weakness. In the crack cocaine population — whose epidemic was met with a law enforcement response that produced the largest incarceration boom in American history while treating centers stood empty — the people who ran out of time were failed at every level: by the pharmacological trap that exploitation and structural poverty made available, by the policy that chose incarceration over treatment, and by a cultural narrative that called the resulting dependency a moral failure rather than what it was.

The biology was never a moral failure. The triple reuptake inhibition that crack cocaine produced was a pharmacological event in a nervous system that the compendium's constitution framework identifies as the Warrior profile — a brain that was always going to be drawn toward maximum intensity, that was always going to find the pipe's signal louder than anything available elsewhere, because the Warrior baseline genuinely required something louder than ordinary life provides.

The crack was the loudest available signal. The recovery is finding what the Warrior brain was always genuinely capable of producing on its own terms — and building the conditions in which that capacity is legible without the pipe.

Every mile run. Every dollar saved. Every person served who was where you were. Every meal cooked. Every child tucked in. Every day sober in the city that sold you the pipe. These are genuine neurological events — dopamine signals, earned rather than stolen, building rather than depleting.

The engine that chased crack through the night is the same engine that wins anything it commits to. The chase instinct does not go away in recovery. It finds an address the pipe could never provide: a life that actually grows.

This guide was written for you. So was everything the Recovery Kernel compendium contains. You are not its afterthought. You are the reason it was built.

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Drug court resources: nadcp.org | Reentry resources: nationalreentryresourcecenter.org | Crack-Cocaine Anonymous: ca.org

Refer to the Recovery Kernel Complete Centurion Compendium for all referenced protocols.

Crisis: call or text 988 | Emergency: 911 | SAMHSA: 1-800-662-4357

⚠ HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE